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(73 member Guilds)

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The Federation of Catholic Physicians' Guilds

The Linacre Quarterly

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President's Page

The Federation of Catholic Physicians' Guilds "comes of age" at the San Francisco meeting during the A.M.A. convention in June. Through the hapless years of adolescence, only the nurturing by and the strength of The Catholic Hospital Association kept it alive. A few short years ago, there were only twelve (12) Guilds; THE LINACRE QUARTERLY was running a year behind schedule in publication; indebtedness to The Catholic Hospital Association surpassed $6,000. Father John J. Flanagan, S.J., Executive Director of The Catholic Hospital Association and Msgr. Donald A. McGowan, Director of Health and Hospitals of N.C.W.C. inherited the cadaveric vestige of an idealistic dream of physicians united in Catholic Action. These two wonderful priests — amazing in their contrasting personalities and inspiring in their unified pursuit of "Good Medicine is Good Catholic Action" — have effected a miraculous convalescence.

This organization now has a roster of seventy-three (73) affiliated Guilds representing thirty-one (31) States, Puerto Rico, and Canada. It has liaison with many more Guilds not at present affiliated. The membership of physicians has now reached the five-thousand (5,000) mark. THE LINACRE QUARTERLY is approaching a distribution of ten thousand (10,000) copies per issue to doctors, priests, libraries, hospitals and others in the health field. This journal is being quoted constantly for authoritative Catholic thought — and most recently, in a new text-book on *Artificial Insemination* by Schellen. This author devotes a page to the Catholic medical opinion as stated by the Executive Board of the Federation in June and reported in the August, 1952 issue. The booth in Exhibition Hall at each A.M.A. convention proclaims "What your Catholic patient believes!" and is staffed by members of the Executive Board and the various Guilds. The response to this booth project has been a most edifying and elevating experience to each doctor who has serviced it during the convention days. Annually, a "Catholic Physician of the Year" is honored. The Thomas Linacre Award is also presented for the best article contributed by a physician.

Through all the executive meetings that have effected this growth and activity, Msgr. McGowan and Father Flanagan, with his devoted executive secretaries, Mr. Ray Kneifl and Miss Jean Read, have been at the right shoulder of your officers to counsel, to aid, to encourage. This year, however, our guardian angels are flying East while we are flying West. The Catholic Hospital Association, of necessity, is meeting in Atlantic City the same week that the Federation is meeting in San Francisco. So, for the first time, the Executive Board will meet without its Moderator and central office staff. How well it does will depend entirely on the number of Guilds having delegate representation.

In this era of Catholic Action — and that your Federation may continue to play an important part in the promotion of Catholic thought in medicine — I urge you to send a delegate from your Guild to San Francisco for the Executive Board meeting on June 25.

WILLIAM J. EGAN, M. D.

Doctor! . . .
There IS *a Father in the House*

Nage Maillew, M.D.

The February 1957 issue of The Linacre Quarterly published an interesting article by Father Edward D. Roche, C.M., entitled "Doctor! Is There a Father in the House?" As the theme indicated, the need for the doctor to be "a father in his house" is a demanding problem in these days of the busy practice of physicians. One doctor whose true identity is withheld at his request has given utterance to his solution of the situation. His words appear here for thoughtful consideration.

From the mouths of babes! My oldest son was only eight when he was first asked if he were going to be a doctor. He quickly replied, "No! Daddy is never home." Forthwith, came the realization of what had been my problem for some time. In endeavoring to fulfill what I had always considered my true vocation, I had failed to realize that, in the blinding glow of wedded bliss, I had vowed to assume a far more basic vocation —that of a father.

Immediately, corrections had to be made. There were many younger doctors anxious to make calls that would give them entree to new acquaintances. The lion of practice that I had by the tail did not have to subsidize me. Even the patient who would see no one but me was surprised to find that he or she could transfer confidence to a younger physician in whom I had confidence. In promoting other physicians, I had the wonderful satisfaction of being magnified by their success, as a father reflects the success of his sons. Patients, who formerly felt frustrated by their dependence upon me, now were secure in the close contact of several physicians.

Meanwhile, "Daddy could be home"—and home took on a new meaning for Mother, the children *and* Daddy. Most dramatic of the changing times was the dinner hour. Formerly, I had rushed into a frantic meal with all children howling at that five-thirty hour, when children—deprived of motherly attention by the distraction of meal preparation—take a fiendish delight in howling. Now I was the man who came to dinner — and stayed. Daddy was not in a hurry, so that there was attention and affection available for each child's hurt of the day. Because the meal was leisurely, the children took time to eat, and in turn, to express their hopes, desires, and worries to an attentive table. Even guessing games could be played as we waited for the slowest eaters to finish. With the meal concluded,

Mother was free to take the toddlers off to bed with time for a pleasant bath, a good story, and that marvelous nightly talk with God and their guardian angel. Clearing the tables and doing kitchen chores became an eagerly awaited pleasure; Daddy was home with the older children. As kitchen foreman, I was available for intimate questioning, problem solving, toy repairing, aid on the heavier chores and, most of all, companionship. With the kitchen spic and span, it was game time—and games, it turned out, are far less complicated and much more fun when an older head is present to referee and supervise as he joins in the fun.

It turned out that Daddy could be a tremendous crutch to eager little fellows. He knew Latin and, surprisingly to his children, could help them learn their altar-boy card much more quickly for he, too, had served for the Holy Sacrifice of the Mass. Studying was not nearly the grind that it had been when, to memorize, you repeated aloud your lesson seven times in honor of the Holy Ghost—for that was the way Daddy had learned to study. It was easy to learn the arithmetic facts (tables to Daddy) as they were chanted while drying the dishes and if you didn't say them quickly enough, one of the others would. Even fractions, geography, Latin, French and physics became more real when you found that Daddy and Mother knew them almost as well as teacher.

More important, however, were the family outings. With a physician available to cover the telephone and the hospital, I was free to organize a Sunday jaunt to a picnic area. In Spring and Fall, Sunday became the day of days. Following Mass, the baskets were packed and the entire family crowded into the car for an adventure in exploration. New areas were constantly found by a lake, in a mountain retreat, by the seashore, beside the highway where children could run off and be cowboys, Indians or just plain woods animals—with an anchor to return to frequently — Mother, Daddy, and the food. With these outings, I discovered more of the native beauty in my area than the children could possibly be aware of; they were compensating us with relaxation and pleasures for which I had never taken time.

Perhaps, one of the most effective results of my being at home was the development of the "Meeting of the Board." At close range it turned out that even Solomon would not be able to make a correct decision in children's arguments at times. There were no falsehoods, you understand; just withholding some of the facts in the dispute. When such a situation arose, it became quite an affair to assemble them all in their chairs at the table and discuss the matter. Soon the correct facts would be forthcoming. Amazingly, disciplinary problems of punishment and of acceptance of punishment became easy. I might add that this "Meeting of the Board" has come up with some solutions of difficulties and some efforts in Christian

Charity that have confounded the parents of "The Board."

And finally, I must mention morning Mass. The time was always there even with the busiest practice, but somehow I didn't know it. When the children found that Daddy was real and part of them, they were free to ask for a ride to morning Mass. First, the urge was to serve as altar-boys. Then the concern was that Johnny So-and-So might not show up to serve, so they had better be there. Then the habit was established so that they arose at a constant hour for daily Mass. And in daily Mass, Daddy became an integral part of his family. Again, I found new Supervision and a new Consultant in my daily diagnosis and surgery.

So, from the "mouths of babes" came a whole new way of life in which I have come to accept my dual vocation: basically, a Father and by choice, a Doctor. God, alone, will give the final accounting. To the best of my ability, however, I can say "Yes, doctor, there *is* a father in the house."

Attention!

Physicians Attending the A.M.A. Convention
San Francisco Civic Center
New Plaza Exhibit Hall
June 23-27, 1958

The Federation of Catholic Physicians' Guilds will again be an exhibitor at the A.M.A. convention in San Francisco, June 23-27. The booth will need staffing. Catholic physicians willing to give a few hours time to meet visitors during the five days of the convention are urged to write:

DR. G. P. J. GRIFFIN
311 Garfield Place
Brooklyn, New York

Please advise the day and time you will be available. The Booth number is **E-33.** Be sure to visit the exhibit and bring others with you.

A SPECIAL DESIGN

Thomas A. Dooley, M.D.

Dr. Thomas A. Dooley is the 31-year-old author of the 1956 best seller, DELIVER US FROM EVIL, *the story of his work as a Navy doctor amongst the Catholic refugees of North Viet Nam. With the royalties from that book he returned and spent 16 months in the jungles of Laos where he built a small hospital. He recently returned to America and has written a new book on his work in a hut of a hospital. It is to be published this month,* **The Edge of Tomorrow.** *He is now currently lecturing around the country and arranging for the departure of the teams of* MEDICO *of the International Rescue Committee. Anyone interested in this program can reach him at* **Box 2, Times Square, New York, New York.**

I once asked a Chinese communist officer, "Why are you, an educated mandarin, a member of the Communist Party?" His reply was staggering. He said, "I am a communist because you Christians are not very good Christians."

It sounds paradoxical. Upon close analysis it makes sense. Honest self-examination reveals that there is a chasm between what we Christians of the world proclaim ourselves to be, and the actual practice of our lives. There is a great deal of blather and bleat these days about "The Brotherhood of Man," "The Community of Nations," "The Love of Mankind," "The Spirit of Humanity." But to many Asians this looks more like selfish national interests, a community of larger nations to control the smaller, a love of mankind—if that segment of mankind follows our policy—and a spirit of humanity—if that portion of humanity can enter into defense alliances with us.

The pious phrases of democracy do not translate well into Asian tongues. Most Asians could not care less about the magnificence of Mount Vernon, or the glories of flush plumbing. Most of them want their own nation respected, their own dignity upheld, and their own voice heard. At Bandung it was said, "For Centuries we Asians have been voiceless in the world. White men have spoken for us. But from now on the world shall hear the voice of the voiceless."

A few decades ago, a voice from Asia meant little to America. Asia was half a world away. Save for the valiant missionaries who fought the savage jungles of the world, few men had much contact with the "yellow hordes" of Asia. Perhaps it was difficult to "stretch" with our christianity that far. Perhaps it was not always economically feasible. But now, in 1958, the earth has shrunk too much to permit Americans to live in an isolated mansion in the midst of world

slums. Two-thirds of the human race today are miserable. To them, adequate medical care is absolutely inaccessible. That is bad enough, but they are maturing, and becoming convinced that their plight is not inevitable. Many blame their situation on the poor administration of their country in the hands of the white man. They are fiercely determined never to be ruled by the white man again. This means rule by any means whatsoever, including economic control. The voice of Asia is being heard and it could well be the herald of world disaster.

If we, of the Judeo-Christian world believe our beliefs, then we recognize our own deep involvement in the lives of men everywhere. If we, as men born in freedom, accept this involvement, then we must accept its challenge. The people of other lands need and seek our service. They do not want our patronage.

Our own country's foreign aid program is doing a great deal to give illustration in deed what we proclaim as our creed. We must continue this if we are to continue to have any form of peace. But a government can go only so far. No government program can ever replace the individual. No foreign economic program can ever replace the individual sense of self-reliance, initiative, or self-responsibility. More must be done and it must be done now.

Distance has dulled our awareness. America is not fully awakened to the realization that medicine is a powerful instrument for international friendship. With medicine we can project our humanitarian impulses across national boundaries, in a way often unrealizable by the desperately needed, but frequently impersonal, government aid programs. From my own personal experiences in a hut of a hospital in Laos, and in the evacuation of more than 650,000 refugees of Viet Nam, I have seen the power of gentleness, the magnificence of kindness. From a moment's glance at the work of such men as Gordon Seagrave, Albert Schweitzer, and Howard Rusk, one can quickly grasp the fact that medicine has a unique role, *a special design* for destiny.

The role of medicine in human destiny is far above the give and take of national rivalries. Medicine rises above the fears of colonialism, or of domination by selfish foreign interests. And at the same time, medicine affords American doctors a unique opportunity for service to all mankind. Our task, as doctors, is to take care of people who are sick. If this has an accompanying result in aid to our nation's interests, then it is, like mercy, "twice blessed."

Our Judeo-Christian school of philosophy speaks of the oneness of man. All man belongs to man. Man has claims on man. The crisis of our day demands a re-affirmation in practice, of this fundamental belief. We must act it out, each of us, individually.

Abandoning now all academic and auspicious verbiage, let me tell you of a bold and ambitious new program, just inaugurated this February. Under the aegis of the International Rescue Committee, a

Medical International Cooperation program has been formed. MEDICO of the IRC has a very simple purpose. We are going to offer person-to-person medical service to the peoples of the world who need us. We are not a charity program. Those we care for will pay us, as my patients paid me in Laos. In my hospital in Nam Tha, a delivery costs a chicken, an operation, a pig, pills cost one egg (and frequently I was forced to "split my fee" with the local witch doctor). MEDICO will send medical teams out into the most miserable villages of the world to simply practice our profession, to take care of people who "ain't got it so good." We are not going to try to make new Republicans, or Irish Catholics out of them. We shall not proselytize. We are a non-government, nonsectarian group. We shall train the villagers to maintain that which we build, without any attempts to make them air-conditioned, chrome-plated, tail-finned isomers of Americans. We shall train the local personnel to a level at which they can handle the basic problems of a "jungle general practice." From my experience in Asia, this should take about 18 months.

We shall build nothing beyond their own capacity to maintain after our departure. No generators, no electronic physiotherapy paraphernalia — nothing that the villagers themselves cannot learn to handle.

We aim at no perpetuity. We wish to work ourselves out of a job. We intend to go to whatever distant village the host government requests. There we shall build, stock, and supply a hospital. Then we will train the personnel. MEDICO wishes to build no dynasties. We want to train indigenous personnel to a level easily reached, without any attempts to make them internationally recognized MD's or RN's. Then when the hut-of-a-hospital is turned over to the host government, the team will move to another area, and build another hospital where the host government so wishes.

I believe that long-range economic aid programs are essential, but indefinite dependence on aid errodes self-respect. MEDICO is aimed at the level of the humanity with whom we shall work, and we intend to work through the host government department of health. We shall endeavor to work ourselves out of a job—as soon as possible.

Each MEDICO team will consist of a physician and several medically trained personnel. Team members will be men and women who are dedicated to service to humanity. MEDICO will enable them to give practical expression of love of mankind—an opportunity altogether too rare amidst the fears and obscurity of our time. We are seeking physicians throughout the country to work with us.

We wish to give capable doctors a place to invest something of their humanity for a few years of their lives.

From the great awareness of the pharmaceutical houses of America, we have already been given more than $600,000 worth of supplies.

The financial support is now being solicited from the general public of this country, living in comparative plenty. So far we are not doing so well in this dollar support, but feel that "with the luck of the Irish" and, most of all, the Grace of God we will make it.

We have been formally invited into many Asian countries, and our experience leads us to believe that the host governments will be willing to furnish the assistance, and personnel needed to complement each team.

We hope that through this program we who believe in God will be better Christians, better men, and closer to Him in our service to "The Least of These."

MEDICO of the International Rescue Committee will not stop the march of communism across the bloody face of the world, but we firmly believe that it is better to light one candle than to curse the darkness.

Dr. Dooley at a Laos Village sick call

BOXING: MEDICAL AND MORAL ASPECTS

Eugene G. Laforet, M.D.

Dr. Laforet is a Senior Teaching Fellow in Surgery, Boston University School of Medicine, and Resident in Thoracic Surgery, Boston City Hospital, Boston, Massachusetts.

Of all extant forms of sport in which man is pitted against man, boxing alone has as its prime and direct object the physical injury of the contestants. Stated thus baldly, boxing would therefore appear to differ intrinsically from all other types of athletic endeavor and thus perhaps to merit more than casual scrutiny. In addition, its distinct formal object raises of necessity certain ethical questions. The marked increase in audience potential resulting from modern media of communication and the concomitant rise of professional boxing to the status of "big business" have established the problem as one of practical importance. This study was undertaken in an attempt to reassess the role of boxing in contemporary society by presenting concrete medical evidence to serve as a basis for an ethical evaluation of the so-called manly art.

DEFINITION AND HISTORICAL SURVEY

According to Webster, boxing is "the art of fighting with the fists, especially when they are covered with padded gloves." This generic definition is quite accurate, although a purist might stipulate that present-day pugilism is essentially an encounter between two men of similar body weight who assail each other with gloved fists under predetermined rules and for a specific duration.

While "the art of fighting with the fists" is probably as old as mankind, John Boyle O'Reilly[1] felt that the Greeks were the first true boxers. He has stated, "Pugilism appears to have been one of the earliest distinctions in play and exercise that appeared between the Hellenes and their Asiatic fathers. The unarmed personal encounter was indicative of a sturdier manhood." One of the first descriptions of a boxing bout is contained in the account of the Argonauts' search for the Golden Fleece, with Pollux conferring unhappy immortality on King Amycus as the first recorded boxing fatality.

When the mists of mythology yielded to the dawn of recorded history, pugilism was already well established. In the era of the Grecian games boxing appears to have been bare-fisted. The Romans added a modification of their own, the murderous *caestus*, essentially a hand and forearm glove loaded with lead or iron. While pugilism in this form enjoyed a huge spectator appeal, the mollifying influence of Christianity and an

understandable dearth of boxing aspirants gradually resulted in its decline. Thereafter little was heard of the sport until the late Renaissance when it reappeared in less savage guise.

In 1719 James Figg of England became the first generally recognized national champion boxer. Attempts were made to codify boxing regulations and "Broughton's Rules" were approved in August, 1743. These continued in force until 1838, when "The New Rules of the Ring" were adopted. Boxing remained a bare-knuckled affair until the late nineteenth century when gloves were introduced, largely as a result of the efforts of John L. Sullivan. The present century has witnessed the rise of boxing to the level of a major entertainment industry with a relatively stable format.

MEDICAL ASPECTS

Since by its nature boxing affords a unique opportunity to study the effect on the human body of relatively well-standardized traumata, it is not surprising that the medical profession has long been interested in this sport. As early as 1848 the first medical report on boxing appeared in the form of a study prepared for the French Academy of Medicine by Rayer-Collard. Subsequently, there has arisen a voluminous literature embracing virtually all the medical aspects of pugilism.

The most comprehensive survey to date has been the monograph of Jokl[2] which was published in 1941. Later studies, both clinical and experimental, have furnished additional valuable data. While it is not feasible in a limited review to condense the vast literature satisfactorily, it is hoped to present an unbiased résumé of pertinent studies. Emphasis has been placed on the more recent contributions, and on statistically significant studies rather than on isolated case reports. When an author on the basis of his investigation has expressed an opinion of boxing as a sport, this has been noted.

Physical and Psychic Advantages

The physical and psychic advantages of boxing as a participant sport are necessarily difficult to quantitate and the problems involved in obtaining objective data have militated against any satisfactory statistical study, However, a survey conducted by Kenny *et al.*[3] among heads of physical education departments enumerates the majority of the benefits usually attributed to boxing (Table I). Little comment is possible or perhaps even proper, but in view of the reputed advantages in self-defense, it would be interesting to speculate on the fate of a boxer confronted by a judo expert or an armed adversary.

Physical and Psychic Disadvantages

Death: The spectre of this most dramatic, though not necessarily most tragic, complication of athletic endeavor haunts every competitive sport as, indeed, it haunts every motorist, pedestrian, and housewife. However, fatalities are likely to occur more frequently in some forms of sport than in others. Because of uncertain data relative to the number of participants in

each sport, it is not ordinarily possible to arrive at a statistically valid incidence of death for each form of competition.

With this stricture in mind, the study of Gonzales[4] is of considerable note since it is based on abundant material passing through the Office of the Chief Medical Examiner of New York City in the 32-year period from 1918 through 1950. Fatal injuries were distributed among the various sports as noted in Table II. It is surprising, at least in the absolute number of deaths, that the relatively placid game of baseball achieves the dubious distinction of first place, with boxing third behind football. Although no facts are presented concerning the actual or estimated number of participants in each sport, the author concludes:

> In recent years, opponents of boxing have expressed the opinion that the sport should be abolished, that it is potentially dangerous and not necessary to the development of those attributes which are most desirable in young men. Thirty-two years of boxing competitions, however, have produced fewer deaths, in proportion to the number of participants, than occur in baseball or football and far fewer deaths than result from daily accidents. It seems that the moral and physical benefits derived from boxing far outweigh the dangers inherent in it or any of the other competitive sports.

The statement that boxing has produced fewer deaths in proportion to the number of participants than has baseball or football appears rather gratuitous when one realizes that, in terms of individual exposure to injury, one baseball game is the equivalent of at least nine boxing bouts and one football game the equivalent of at least eleven. In addition, Gonzales' proposition is hardly aided by the impression that the number of baseball and football contests at all levels of play probably far exceeds the total number of boxing bouts.

Cranio-cerebral injury — acute: The incidence of acute severe cranio-cerebral injury in boxing is not readily determined since no extensive, accurate, and continuing statistical survey is maintained. However, in his monograph Jokl[2] has collected forty-three reports of fatalities in the ring. Accurate necropsy findings were available in thirty-seven, in twenty-four of which the cause of death was cranio-cerebral injury, usually associated with hemorrhage. Injuries to the cervical spine and underlying cord accounted for an additional two fatalities. It is therefore evident that death during or shortly after a bout is most often the result of acute cranio-cerebral injury.

Chenoweth[5] believes that screening of boxers by skull x-rays will furnish a partial safeguard against such injuries by eliminating those whose calvarium is abnormally thin and who therefore are thought to have an increased susceptibility to intra-cranial injury. Various headguards have been devised which are in general use for training bouts and are mandatory for intercollegiate boxing. There is little evidence that such apparatus significantly reduces the hazard of severe head injury[2] although many superficial lacerations may be prevented thereby.

Cranio-cerebral injury — cumulative: More insidious, but hardly less important than acute brain injuries, are the cerebral changes in-

duced by repeated sub-lethal head trauma. In 1928 Martland[6] became one of the first to call attention to this syndrome in boxers. He felt that definite anatomic changes could be found to account for the clinical picture and stated that nearly "50% of fighters who stay in the game long enough, develop punchdrunk." Eight years later, Carroll[7] published his now-classic description of the evolution of punch-drunkenness and estimated that 5% of subjects who box professionally for five or more years exhibit definite evidence of the syndrome and in the same period a full 60% will develop nervous and emotional changes which are obvious to those who knew them previously. He maintains that "no head blow is taken with impunity and . . . each knockout causes definite and irreparable damage. If such trauma is repeated for a long enough period, it is inevitable that nerve cell insufficiency will develop ultimately, and the individual will become punch-drunk."

This standard concept of the development of brain injury in boxers has been questioned by Kaplan and Browder[8] who studied 1,043 boxers in a four-year period. Observations at the ringside and after the fight revealed no neurologic deficit in the contestants, even in those who had been knocked out. Electroencephalographic data were also collected and the writers concluded that "correlation of the physical features and performance data of each fighter with the electroencephalogram failed to reveal any significant statistical results, except in the rating class in which statistical results indicated that those lower in ring rating have the greater percentage of disorganized electroencephalograms."

Harris[9], however, challenges the interpretations of these investigators and suggests that they offer no proof that the punch-drunk syndrome does not exist. In a smaller study, Busse and Silverman[10] have presented evidence that objective changes do occur. Electroencephalograms were performed on twenty-four boxers and a statistically significant increased incidence of dysrhythmic records was found (nine, or 37.5%). They also reported that fighters who had been knocked out showed more severe disturbances than those who had not. Although evidence on specific points may be conflicting it is difficult to believe that the punch-drunk syndrome is an unproved figment, as Kaplan and Browder imply.

Injury to the visual apparatus: Under this category Doggart[11] describes three types of derangement due to boxing: (a) ocular damage, (b) injuries to neighboring structures, including the ocular adnexa, and (c) lesions of the visual pathways and other parts of the brain.

With respect to ocular damage, Albaugh[12] states that:

> Although similarities exist between the types of eye injury resulting from boxing and those resulting from other occupations, some important differences must be noted. . . . Damage to the eye is almost always the result of a direct blow upon the eyeball, and is usually severe enough to cause profound pathologic changes. . . . One of the tragic features of eye injuries sustained in boxing is that all too often they are bilateral, and therefore

completely disabling. In the series of one hundred fifty-four eye injuries included in this study, eighteen were bilateral (almost 12%).

Boshoff and Jokl[13] reported ten cases of severe eye injury due to boxing and feel that from the aspect of potential eye trauma alone, boxing should be condemned as a sport. They state, "Evidence is on record to the effect that among major sports, boxing occupies a special position, since it deliberately aims at producing head injuries."

Doggart[11] appears to speak for the majority of ophthalmologists when he writes:

> All medically qualified people have had the opportunity to dissect the head and neck. These are not the only targets for disabling blows, but we know that they are the most important, because they contain the seat of intelligence, together with a most fragile set of sense organs, a sequence of delicate nerves, and a number of other structures nourished by richly anastomosing blood vessels. The very thought of setting out to smash all this artistry is sacrilege, not sport. . . .

Maxillo-facial and aural trauma: Because of the nature of boxing, trauma to the maxillo-facial and aural areas is quite common. The repeated occurrence of hematomas of the ears frequently results in the occupational stigma known as "cauliflower ears." The wearing of a properly fitted mouth-piece has reduced but not eliminated the possibility of broken teeth. Zygomatic arch fractures are not unusual. Due to its prominence the nasal region is often injured and it is the rare boxer whose nose retains for long its pristine configuration. Seltzer[14] has been impressed with the loss of vascularity in the noses of boxers who have had fifty or more bouts and states that repeated injuries so destroy the septum and the normal nasal lining, with replacement of dense scar of connective tissue, that vascularity is reduced.

Renal damage: Although trauma to the head, thorax, and epigastrium has long been recognized as an obvious feature of boxing, a recent study[15] has directed attention to the occurrence of renal injury. With the cooperation of the New York State Athletic Commission, urinalyses were performed on professional boxers who fought at Madison Square Garden and St. Nicholas Arena in New York City during 1952 and 1953. One hundred and thirty nine boxers were examined. In 46% the urine changed from clear before the bout to cloudy afterwards. Albuminuria, not present prior to the contest, was found in 68% of the fighters at its conclusion. Red blood cells in significant pathologic amount were present microscopically in 73% after a fight, and granular or hyaline casts in 26%.

Since erythrocytes and casts in the urine are not found after strenuous exercise alone, it becomes apparent that the factor of trauma is of major importance. With respect to the incidence of abnormalities in the urine, the only correlating factor was found to be the number of rounds boxed by the subject. Thus, while hematuria was present in 65% of boxers after one to six rounds, it occurred in 89% of boxers who fought from seven to twelve rounds. In the latter group, the number of red cells was greater and four fighters in this category had total gross hema-

turia. A similar correlation existed for albuminuria, which was present in 60% of subjects who had boxed one to six rounds and in 87% of those who had fought for seven to twelve rounds.

Although it is therefore evident that acute renal trauma occurs in the majority of boxers during a bout, the long-term effect of such trauma in terms of scarring of the kidneys and possible permanent renal impairment has not yet been evaluated.

Miscellaneous injuries: The occurrence of a multitude of less common injuries associated with boxing has been documented by Jokl[2]. These include rupture of the spleen, perforation of the small bowel, traumatic hemothorax, myocardial contusion, and a host of others. The diagnosis and surgical treatment of an interesting occupational disability, "boxer's knuckle," has been described by Gladden.[16] Generally speaking, however, hand injuries are sustained by boxers far less commonly today than in the era of bare-knuckle pugilism. In this connection O'Reilly's[1] plea for the adoption of gloves is of interest:

> The brutalities of a fight with bare hands, the crushed nasal bones, maimed lips, and other disfigurements, which call for the utter abolition of boxing in the interests of humanity, at once disappear when the contestants cover their hands with large, soft-leather gloves.

Unfortunately, this sanguine prediction has been countered by sanguinary fact, and Doggart[1] maintains that gloves are a protection to the wearer's fist and not to the opponent. It would certainly appear true that bare-knuckle boxing, with the fragility of the unprotected fist as an in-built safety factor, might be a generally less hazardous method than that currently employed.

MORAL ASPECTS

Among moralists, proponents of the licitness of boxing are exceedingly few, and even they hedge their position with numerous strictures, many of which can be verified in theory only. Perhaps the most comprehensive analysis of the moral question is that of Bernard[17] who reached the conclusion that professional boxing as it exists today "is immoral and should be condemned." Furthermore, while granting certain differences, he indicates that amateur boxing at the practical level shares in this condemnation. This is the position which the majority of modern theologians who have discussed the question prefer to defend—not as the official teaching of the Catholic Church (which on this question simply does not exist), but as a matter of private conviction formulated by applying their moral principles to the facts as they understand them.

One of the first on the modern American scene to question the morality of prizefighting was Connell:[18]

> Boxing, in the sense of giving and parrying light blows without any intention of striking the opponent severely or inflicting injury, is lawful for the purpose of exercise and recreation, and in order to test one's skill in self-defense. But it is difficult to reconcile prizefighting, as we have it today, with Catholic principles of morality. For, undoubtedly, the purpose of the fighters is to deal each other severe blows, and if possible to score a "knockout." That grave injuries frequently come to those who follow prizefighting as a career is well known from experience.

The fact that both contestants willingly submit to the probability of being severely pummelled does not alter the case, since a man has no right to allow another to beat him, apart from justifiable punishment. Neither does the fact that the combatants will be paid a large sum of money justify a means that is unlawful.

Even boxing may easily assume sinful features. Speaking of this sport, Damen says: "This type of contest can easily become unlawful, either venially or mortally, in accordance with the degree of the more or less probable danger of injury or even of death — for example, if the due cautions are not observed or if the contest tends to the 'knock-out' of one of the fighters."

This opinion may seem somewhat severe in view of the widespread conviction of the American people that prizefighting is "good, clean sport." Yet, it is difficult to see how any other interpretation of the fifth commandment can be given.

Rendering a minority report, Healy[19] had previously stated:

The practice of professional boxers of trying, by means of a knockout, to render their opponents helpless is justifiable. These boxers do not do the opponent serious injury. Ordinarily, the one who is thus knocked out is simply put into a state where he is unable, for a few minutes, to continue the bout. He is still conscious, though temporarily incapacitated. If at times the man is rendered unconscious, that is merely accidental.

What is to be said of "slugging fests" — that is, of prizefights where each boxer mercilessly pounds the other? These matches savor of brutality and so are reprehensible.

The theological arguments most commonly employed against the licitness of prizefighting would appear to be reducible to these:

1) The "sport" of *its very nature* tends to result in serious and unjustifiable injury to its participants. Not only is the knock-out itself an unjustified mutilation of the rational faculties, but — even more important, apparently, in the minds of some — the preliminary softening-up process, with its external lacerations and damage to internal organs, is also without moral justification.

From a medical point of view this is perhaps the most cogent argument that could be advanced against prizefighting, and it was with the intention of providing evidence to warrant this medical conclusion as a theological suppositum that the present study was undertaken. When hematuria occurs in 65-89% of boxers after a bout, then each blow to the flank tends to produce renal damage, and this is entirely independent of the intentions that accompany the blow. And when 60% of boxers develop neurologic and psychic changes in the brief span of five years, it follows that each blow to the head tends to produce profound cerebral damage, regardless of the immediate intent with which it was delivered. The medical data already detailed appear sufficient to refute any contention that a knockout and the preliminaries thereto are usually *in se* innocuous to the victim.

2) These same effects, according to the majority of moralists, are also the *direct object of the prizefighter's intention*. It is totally unrealistic, they insist, to pretend that a boxer only permits, and does not deliberately intend, the damage he inflicts on his opponent in order to win a bout. Any attempt to apply the principle of double effect is thereby immediately doomed to failure.

Prizefighters themselves and boxing fans would be the first to admit that this is so, even though they might scoff at the moral implications of their admission. Win-

ning by a knock-out (K.O.) is considered superior to winning by a technical knock-out (T.K.O.), and the latter is in turn preferable to winning on points. (And as for the mere "giving and parrying [of] light blows without any intention of striking the opponent severely or inflicting injury" — such an exhibition would be booed lustily out of any fight arena.) Since in boxing, even more than in other sports, the object is to win as decisively as possible, it follows that the scoring of a K.O. is greatly desired by boxers. Failing this, a T.K.O. may be sought by attempting so to disable an opponent that continuation of the bout would gravely imperil his health even in the judgment of a non-medical observer. To this end the attack is often concentrated on an already injured area (e.g., a supra-orbital laceration or a peri-orbital hematoma) in order to compound the injury and secure a T.K.O. That the infliction of injury in this fashion is encouraged over proficiency in the science of boxing is indicated also by the not uncommon occurrence of a fighter who is far ahead on points losing a bout by a T.K.O.

3) Prizefighting of its very nature, say the theologians, appeals primarily to the brutish instincts of participants and spectators alike, and therefore constitutes a deordination of rational nature.

Moralists are perhaps best qualified to judge just how brutish a human may allow himself to become, short of sin. But certainly the howling approbation of a blood-thirsty mob witnessing a slug-fest is a spectacle of which rational nature should be less than proud.

PROFESSIONAL VERSUS AMATEUR BOXING

The objection may be raised at this juncture that the condemnation of boxing as elaborated in the foregoing may be applicable to the professional sport but should not extend to the amateur variety. While it is true that more protection may be afforded the amateur boxer in terms of shorter bouts, heavier gloves, and better medical supervision, the fact remains that boxing by its nature tends to the injury of the contestant and that amateur boxing must, therefore, share the condemnation accorded its professional counterpart. Bernard[17] feels that the amateur tournaments such as the Golden Gloves and A.A.U. often partake of the essence of professional boxing. He singles out collegiate boxing as perhaps the most benign of the various forms of amateur pugilism, but states that even in this sphere, "there is (more often) at least venial sin because the blows, although not delivered with the same intent nor the same fury of power as in prizefighting, are immoderate to a marked degree. The same holds true for amateur boxing. This latter, especially with regard to the tournaments mentioned above, frequently becomes gravely sinful because the intent to injure and to knock out is present."

PREVENTIVE MEDICINE

With boxing a *fait accompli* numerous medical groups, spurred by its obvious inherent dangers, have

attempted to reduce the hazards to a more reasonable level.[5 20 21 22] Cooperation on the part of the boxing industry has often been less than ideal,[21] which again suggests that injury is such an integral part of the sport that efforts to reduce the danger are considered meddlesome. Nevertheless, various state boxing commissions (notably those of New York, Illinois, and Colorado) have established certain medical regulations designed to protect the physical well-being of the boxer.

Scholastic boxing has been disapproved by the Joint Committee on Health Problems in Education of the National Educational Association and by the American Medical Association.[22] The Committee based its action "primarily on the premise that boxing is one of the few sports in which the offensive goal is to strike the opponent and in which the head is a principal target." Inter-collegiate boxing has similarly been de-emphasized.

That the various amateur tournaments continue to flourish is perhaps indicative of their true role as pre-professional training farms. While increased cooperation with medical agencies on the part of the boxing industry may well reduce the incidence of injury and death, such revisions as would make boxing medically and morally acceptable would tend to render the sport as it is practiced today nonexistent. Suggestive of this estimate is the statement of Rev. Gerard Gray Grant, S.J., Professor of Philosophy at Loyola University in Chicago, that "we have to classify prize fighting as morally evil and it will remain so until a second foul line is established at the chin."[23] Although it would undoubtedly diminish the incidence of cranio-cerebral injury, even such a stringent requirement as this would not alter the morally unacceptable purpose of boxing, which is to inflict injury on the opponent. Furthermore, concentration of blows on the thorax and epigastrium might well result in an increase in the number of injuries to the intra-thoracic and upper abdominal viscera.

EPILOGUE

Perhaps because boxing more than any other sport concretizes man's primal urge to self-preservation, the emotional overtones which suffuse it are strong. In the foregoing it has been difficult to subdue such elements. Boyhood memories of a youthful, clean-cut Ernie Schaaf entraining from Boston's South Station for New York and eternity vie with the thrill of the incomparable Graziano-Zale triad. And there are other vignettes — the raw excitement of the Dempsey-Willard battle preserved on celluloid, the superb artistry of Joe Louis, the young Golden Glover on a tray in the Kings County morgue. The innate appeal of boxing as a spectator and participant sport must therefore be assumed, as also must the revulsion that accompanies its tragedies. Its justification or condemnation, however, should transcend the emotional and rest on the firmer ground of rationality. From this aspect, it has been demonstrated as at least strongly probable that

boxing should be condemned on both medical and moral grounds. The moral condemnation rests chiefly on the fact that boxing's prime objective, both from the nature of the sport and from the intention of the contestants, is the unjustifiable injury of the participants. Salient support is afforded this ethical view by medical evidence which indicates that boxing is always potentially dangerous to life and health, and often actually so.

SUMMARY

Boxing is unique among sports because its prime and direct object is the physical injury of the contestants. With various modifications it has existed as a form of athletics since the beginning of recorded history. The physical and psychic advantages attributed to it as a participant sport are nebulous and are shared by many safer modes of competition. Its physical and psychic disadvantages, on the other hand, are overwhelming, as shown by a survey of pertinent medical literature.

Boxing is morally wrong in the opinion of most modern theologians. Their most cogent argument derives from the contention that boxing *of its nature,* as well as *by the direct intent of its participants,* is designed to result in serious and unjustifiable bodily harm. This condemnation should, it seems, extend to the amateur as well as to the professional form of the sport, since only accidental differences exist. No amount of medical supervision is likely to render boxing morally more acceptable without resulting in an essential change in the sport as it exists today.

(Tables follow)

TABLE I

Reasons why boxing should be or is included in varsity, intra-mural, or physical education sports curriculum.*

	NUMBER	PER CENT
Physical development	23	53
Self-defense	19	44
Poise	8	19
Interest or popularity among student body	7	16
Confidence	6	14
Valuable exercise	6	14
Opportunity for all weights	5	12
Alertness	5	12
Courage	5	12
Self-control	4	9
Skill	4	9
Expression which cannot be satisfied in other sports (urge of combat, inherent desire to use fists)	4	9
Agility	3	7
Ability to give and take	3	7
Sportsmanship	3	7
Initiative	2	5
Wholesome pleasurable sport	2	5
Character building	1	2
Respect for other fellow	1	2
Development of personality	1	2
"Carry-over" benefit	1	2
Brings out gentleman in man	1	2
Variety	1	2

* from Kenney *et al.*[3]

TABLE II

Number of fatal injuries in various sports occurring in New York City from

1918 through 1950*

Baseball	43	Wrestling	2
Football	22	Cricket	1
Boxing	21	Golf	1
Basketball	7	Polo	1
Handball	3	Relay Races	1
Soccer	2		

*modified from Gonzales.[4]

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WHAT PRICE TUBAL LIGATION?

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In the past decade there has been an appalling increase in the incidence of surgical procedures designed specifically to interrupt the continuity of the fallopian tubes in an effort to prevent future pregnancy. Coincidentally, the medical indications for therapeutic abortion have been drastically reduced during this same period of time. This state of affairs is more than a paradox; medically speaking, it is an outright contradiction.

Both of the above procedures are similar insofar as they are primarily intended either to *prevent* a future pregnancy, by tubal ligation, or to *destroy* an existent one, by therapeutic abortion; and the motivating force behind each is obviously in direct opposition to the fundamental concepts of the natural law. However, careful analysis will also reveal that, from a purely medical point of view, they are contraindicated.

Bitter experience has taught that the so-called "increased load of pregnancy" has a decidedly *less* harmful impact upon the physical well-being of the individual than does the actual termination of pregnancy by direct and wilful interference — therapeutic interruption — a fact recognized by even the most ardent supporters of such a practice, and the principal reason why this procedure has fallen into medical disrepute.

Further, the widely publicized educational programs to provide better pre-natal care, the introduction of broad spectrum antibiotics to combat the threat of infection, the advances in cardiac surgery to rehabilitate the previously incapacitated rheumatic patient, exchange transfusions for infants with hemolytic anemia, and the crusade against the use of the classical cesarean section with the hazard of potential uterine rupture in subsequent pregnancies are but a few of the many contributions toward "safe deliverance" and the resultant decline in therapeutic abortions.

From the above, one would certainly expect that the incidence of tubal sterilization should at least parallel the reduction in the number of abortions — to postulate otherwise would seemingly contradict these tremendous accomplishments in the field of obstetrics.

That such is not the case, however, is obvious from mere perusal of the current literature wherein is provided the answer to this apparent paradox. The majority of tubal sterilizations are performed either at the suggestion of the physician or in response to patient request, and "great multiparity" is the motivating force. Such an indication is impossible to condone on a bona fide medical basis, and should be more appropriately categorized in the social and/or economic sphere. It would seem that the attending physician has assumed the role of the family social and/or economic advisor, a self-created position wherein he is frequently ill-advised and certainly ill-qualified.

Further analysis of published reports on this subject indicate that the proponents of tubal sterilization speak glowingly in terms of success in the prevention of future pregnancies. Little or no concern is given to the possible consequences for the patient who submits to this type of surgery; such as the immediate post-operative morbidity and mortality — admittedly infrequent, but ever a threat and a factor for consideration in any contemplated surgical endeavor. Again, late sequelae such as therapeutic failures (subsequent pregnancies), psychosomatic disturbances, menstrual irregularities, and the mental trauma which may and often does accompany the realization that reproduction is no longer possible, are individual problems which, at times, far outweigh any medical justification for the surgical interference itself.

Failure to appreciate the existence of these post-sterilization complications may well be partially the fault of the individual patient concerned, for in this era of medical specialization and with the realization that the problem at hand is not of an obstetrical nature, she is more likely to seek advice and treatment from a gynecologist rather than from a physician who limits his practice to obstetrics only.

That such an explanation is plausible is evident from the records compiled at a renowned nonsectarian, university-connected gynecological hospital wherein at one time tubal ligations were considered to be a sound surgical procedure primarily intended to protect the physical well-being of the individual against the alleged burden of pregnancy.

Since 1943, however, this procedure has been looked upon with disfavor due, in most instances, to the increasing number of patients who, subsequent to tubal ligation, were admitted for a superimposed gynecological problem necessitating the additional surgery of hysterectomy.

In support of the above, a statistical study was undertaken at this above-mentioned hospital to evaluate the end results of one hundred patients with previous tubal interruption. In each instance the ligation had been performed elsewhere, and the patients were admitted because of a gynecological disorder for which they sought treatment.

A survey of the indications for the previous tubal ligation was ap-

praised by a group of physicians, and the expressed opinion substantiated this author's contention, for more than 90% had indicated no bona fide medical basis for the sterilization procedure.

Intractable pelvic pain and/or dysfunctional vaginal bleeding represented the complaints of at least 90% of these patients upon readmission. Four patients sought "deligation" in an effort to restore the continuity of the tubes.

Further, in each instance a total hysterectomy was considered the only logical procedure to correct the gynecological disorder associated with a "sterile uterus" which, in itself, had no future purposeful physiological function.

Histological study of the removed specimens — uteri, tubes, ovaries — revealed the following: pathological changes in the ovaries included peri-oophoritis, premature senescence, endometriosis and cortical stromal hyperplasia—each of which could well explain the menstrual irregularities, and was considered the responsible factor in 59% of the series. Chronic salpingitis and the pain associated therewith was noted in only 7%. 18% of the uteri contained either submucous leiomyomata or endometrial polypi which precipitated the profuse and/or irregular menstrual flow. Carcinoma of the endometrium and/or the cervix was encountered in 6% while an additional 7% disclosed marked anaplasia which in itself would have necessitated continued "follow up" examinations were the uterus not removed. Three patients proved to be "surgical failures"—two miscarriages and one ectopic gestation. Of interest was the fact that tubal ligation was unsuspected preoperatively in seven instances—the patients were apparently unaware that such a procedure had been previously performed.

Thus, analysis of the above serves only to confirm this author's initial contention—that tubal sterilization is a procedure which, along with therapeutic abortion, should be recognized as obsolete, since it is not only morally untenable but obviously medically unsound.

Furthermore, the physical well-being of the individual will be better protected when the medical profession at large appreciates the high incidence of these late sequelae which often necessitates additional surgery such as hysterectomy and thereby nullifies any benefit allegedly accruing from the initial procedure itself.

A PAINFUL VERSE

THE WARD WAS FULL OF AILING MEN,
THE AIR WAS FULL OF GROANING,
THE DOCTOR ENTERED, FULL OF FUN,
"GOOD MOANING, MEN, GOOD MOANING."

Reprinted from St. Francis Thermometer
St. Francis Hospital, Carlsbad, New Mexico

PLAN EARLY FOR ST. LUKE'S DAY OBSERVANCE . . . .

Preparations for The White Mass, the annual observance to honor St. Luke, Patron of Physicians, on October 18, his Feast Day, will soon be made locally. To give assistance in making plans, the publicity prepared by the Shreveport, Louisiana Guild is indicated here. With an invitation is included the informational brochure concerning the Mass, set forth below.

What is the White Mass?

It is an annual gathering for public worship by those who care for the sick:

—in adoration of the Creator of all life by the men and women who cooperate with God in its preservation here on earth,

—in union with Our Lord Jesus Christ, Healer of bodies as well as Savior of souls, Divine Comforter of the afflicted and the halt and lame,

—under the patronage of St. Luke the Evangelist, himself a physician and for nineteen centuries world-wide model for the medical profession.

—to emphasize the truth of the Spirit in man, who through the sublime instrumentality of parenthood is composed of body and soul, matter and spirit, immortal through the endless ages after death.

—in testimony that we humans are made to the image and likeness of God, made to know Him, love and serve Him that we might become sharers in His Divine Life here and in the eternity to come.

The White Mass, the Memorial Sacrifice of Our Lord's death on the Cross, is likewise offered:

—a group tribute to all in our community who care for the sick,

—that their dedication to their Christ-like vocation may be renewed with the noblest of motives,

—to express our admiration for medical science and its never tiring research to relieve man's suffering,

—in appreciation by mothers and fathers for the devotion and self-sacrifice of doctor, nurse and all others who care for our families and friends in time of crisis and sorrow,

—in token of homage and esteem by our Bishop and clergy as ministers of souls and to you who minister to the body and mind of man's natural life.

PROPOSED PLAN FOR OBSERVANCE OF THE "WHITE MASS"

Arrangements Committee — all members, Catholic

Chairman — President of Guild, with two other members assisting
One Dentist
Two Nurses
Laboratory technician
X-ray technician
Pharmacist
Pharmaceutical detail man
Hospital Administrator
Physio-therapist
One representative from each private nursing registry
Two medical students
Nursing student (one from each training school)
Women's Auxiliary Catholic Hospital and Medical Society, one each
Physician from Veterans' Hospital
Physician from local Army, Navy or Air Force
Chaplain of the Guild

Each member is responsible for informing respective organization of the "White Mass" and of mailing invitations which advise of place, time, and (evening) reception that includes members, Catholic and non-Catholic, and their families. The notice should be published in all the monthly bulletins of the groups and announced at meetings. Secure hospital permission to post an invitation on bulletin board.

Publicity Committee

Secular Press
Diocesan Press
Catholic Church Bulletins

Entertainment Committee

Arrange for refreshments after Mass, served by wives of Guild members.

Ushers Committee

Guild members should form this committee and direct the seating.

Servers Committee

If possible, have Guild members serve the "White Mass."

Speaker's Committee

The Moderator of the Guild should, if possible, offer the Mass.
The Ordinary of the diocese or some outstanding priest speaker should be asked to give the sermon.

Every effort should be made to make this a united offering of the "White Mass" by all men and women "in white" who serve the sick.
If possible, it should be a Dialogue Mass, with the leaflet missal distributed to those attending and following in English, if that is more feasible.
An added touch is for all Guild members to wear a white carnation.
Assign all Guild members to a committee to give them an active part in the observance of the "White Mass."

FEDERATION EXECUTIVE BOARD MEETING SCHEDULED

The Executive Board of The Federation of Catholic Physicians' Guilds will meet June 25, 1958, 9:30 a. m. at the Sir Francis Drake Hotel, San Francisco, California.

The Officers of the Federation and one delegate from each active constituent Guild constituting the Board will conduct business.

Roll Call

CATHOLIC PHYSICIANS' GUILDS

The listing below gives the name of the president and moderator of each Catholic Physicians' Guild affiliated with the Federation. These groups constitute the national organization.

	President	*Moderator*
ALABAMA		
Mobile	J. O. Muscat 255 St. Francis Street	Rev. P. H. Yancey, S.J.
ARIZONA		
Phoenix	Victor A. Mulligan, M.D. 5340 North 25th Place	Rev. John P. Doran
CALIFORNIA		
Los Angeles	Francis C. Werts, M.D. 1233 N. Vermont Avenue	Rt. Rev. Msgr. J. J. Truxaw
Sacramento	Arthur F. Wallace, M.D. Forum Building	Rt. Rev. Msgr. Thomas Markham
COLORADO		
Denver	John F. Harrington, M.D. 1850 Williams St.	Very Rev. Msgr. David Maloney
CONNECTICUT		
New Haven	David Conway, M.D. 1427 Chapel St.	Rev. John C. Knott
Norwich	John W. Suplicki, M.D. 40 Slater Avenue	Rt. Rev. Msgr. John J. Reilly, V.G.
Stamford	James V. Halloran, M.D. Mason Street Greenwich, Conn.	Rt. Rev. Msgr. N. P. Coleman
DELAWARE		
Wilmington	John G. Graff, M.D. 1407 Woodlawn	Rev. Eugene Clarahan
ILLINOIS		
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Rock Island	C. P. Cunningham, M.D. 414 Safety Bldg. Rock Island, Illinois	Rev. John O'Connor

INDIANA	
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Douglas Giorgio, M.D. St. Mary's Hospital	Rt. Rev. Msgr. Thos. J. Clark
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Carroll O'Rourke, M.D. 604 W. Berry Street	Rev. Albert Senn, O.F.M.
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IMPORTANT EVENTS . . .

Catholic physicians attending the A.M.A. convention in San Francisco will have a busy day, June 25. The Federation is sponsoring the activities we enumerate here —

Memorial Mass

Notre Dame des Victoires Church, 566 Bush Street, 8:00 a. m. . . . . All Catholic physicians and their families are invited to assist at the Holy Sacrifice of the Mass for deceased members of the Federation of Catholic Physicians' Guilds and the medical profession.

Executive Board Meeting

The Executive Board Meeting is scheduled for 9:30 a. m. at the Sir Francis Drake Hotel, Powell at Sutter, within walking distance of Notre Dame des Victoires Church. Early appointment of Guild delegates urged to provide adequate meeting room. Session will close at 1:00 p.m.

Reception

The Federation Officers and Board members will be hosts at a reception from 4:00 until 6:00 p. m. at the Sir Francis Drake Hotel. The invitation is extended to all Catholic physicians attending the A.M.A. convention and is not limited to Guild membership. Please indicate below your intention to attend and mail to the central office. This will assist the Catering Manager in preparing refreshments. You will be the guest of the Federation.

Federation of Catholic Physicians' Guilds
Miss Jean Read, Asst. Secy.
1438 So. Grand Blvd.
St. Louis 4, Missouri

Please include me as a guest for the Federation of Catholic Physicians' Guilds Reception, June 25, 1958, from 4:00 to 6:00 p. m., at the Sir Francis Drake Hotel, San Francisco.

Name Address City and State